Jennifer Snow, D.O.

Patient Name:____

Age / Date of Birth:____

What do you prefer to be called? ________________________________

What is your understanding of why you are being seen?

____

Symptoms related to above?

____

____

REVIEW OF SYSTEMS

GENERAL

Chills
Fatigue
Fever
Night Sweats
Weight Gain > 10lb
Weight Loss > 10lb
Nausea

HEMATOLOGY

Abnormal Bleeding
Anemia
Easy Bruising
Enlarged Lymph Nodes
Nose Bleeds
Prolonged Bleeding

GASTROINTESTINAL

Abdominal Pain
Black Tarry Stool
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Vomiting

SKIN

Bruising
Rash
Color Changes

FEMALE GU

- Abnormal Vaginal Bleeding
- Menstrual Irregularities
- Pelvic Pain
- Urinary Complaints
- Vaginal Discharge

MALE GU

- Lump in Testicle
- Penile Discharge
- Prostate Conditions

HEENT

- Headache
- Blurred Vision

MUSCULOSKELETAL

- Bone Pain
- Muscle Pain

RESPIRATORY

- Chronic Cough
- Difficulty Breathing

NEUROLOGIC

- Headaches
- Numbness
- Weakness

BREAST

- Breast Mass
- Breast Pain (if yes, rate 1-10)
- Breast Swelling
- Nipple Discharge
- Nipple Pain
- Skin Changes
- Change in Breast Size

PSYCHIATRIC

- Anxiety
- Depression
- Insomnia
- Panic Attacks
- Suicidal Ideation

CARDIOVASCULAR

- Chest Pain
- Irregular Heart Beat
- Rapid Heart Rate
- Shortness of Breath

ENDOCRINE

- Colon Intolerance
- Hair Changes
- Heat Intolerance
- Hot Flashes
- Libido Changes

PATIENT NAME________________________________ DATE OF BIRTH _______________

PHYSICIANS

Referring Physician ____________________

Primary Care Physician_________________

Gynecologist __________________________

Other physicians you wish to update ________
____
____
____

FAMILY HISTORY: *(list family member, if on your mother's or father's side, and age of their diagnosis)*

Breast Cancer _________________________
____
____
____

Ovarian Cancer ________________________
____
____

Other Cancers _________________________
____
____

Other significant family history *(heart disease, diabetes, etc.)* _________________________
____
____
____
____
____

Pharmacy Name _______________________
Phone Number _________________________
Address ______________________________
____

MEDICATIONS: list all prescription medications, vitamins, supplements and over the counter medications with dosage _______
____
____
____
____
____
____
____
____
____

ALLERGIES (please list your reaction to each medication) _____________________
____
____
____
____
____

Do you have an allergy to a contrast medium/dye? **Y** **N**
Do you have an allergy to shellfish? **Y** **N**
Are you claustrophobic? **Y** **N**
Do you have an implanted device? (pacemaker, bladder stimulator, metal plate/ rods, etc.) **Y** **N**
Do you have an Advance Directive Document? **Y** **N**
Would you like to provide a copy of the above? **Y** **N**

If you have Medical Power of Attorney, list name below: _________________________
____

If you have a Financial Power of Attorney, list name below: ______________________
____

Please list a good contact telephone number(s) for me to reach you, if more than 1, list in order of preference. ____

If you do not answer the number listed, is it ok to leave a message? **Y** **N**

SOCIAL HISTORY:

Occupation _________________________________ Marital Status _______________________

Children (list their names/ages) ____

Religious Preference: ____

Answer "Yes" / "No" to the following. (If "Yes", indicate amount and how many times per day or week)

Caffeine **Y** **N** ____

Alcohol **Y** **N** ____

Tobacco (Please circle one below) **Y** **N**

Never / Previous / Current -- If so, list # of PPD __________________________________

Illicit drugs **Y** **N** ____

Exercise **Y** **N** ____

Do you use a cane/walker/wheelchair? **Y** **N**

I certify that the information I have provided is correct. I will not hold my doctor or members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature:____

Today's date:____

Have you had the flu shot this season? **Y** **N**

Have you ever had any problems with anesthesia? **Y** **N**

If so, please list ____

Can you walk a block or climb a flight of stairs without short of breath? **Y** **N**

ADDITIONAL HISTORY

Bra Size________________________________

Last Menstrual Period ____________________

Age of First Period

____

Date of Last Pap Smear _________________

Method of Contraception

____

Are You Pregnant? **Y** **N**

Are You Breast Feeding **Y** **N**

Age at First Pregnancy ___________________

Age at First Live Birth ___________________

# of Pregnancies / Live Births _____________

Age at Menopause ______________________

Hormone replacement therapy (monthly)

Y **N**

History of hormone replacement therapy?

Y **N**

If yes, how long _________________________

Do you do self breast exams? **Y** **N**

PAST SURGICAL HISTORY

Appendectomy
Back surgery
Breast biopsy
Breast implants (list type if known)

____

Cataracts
C-section
Colon surgery
Gallbladder surgery
Heart surgery
Hemorrhoid surgery
Hysterectomy *(removal of the uterus)*
Do you still have your ovaries?
Y **N**
Hernia repair (list type) _______________
Lumpectomy
Mastectomy
Splenectomy
Thyroidectomy
Tonsillectomy

OTHER MEDICAL CONDITIONS & DIAGNOSIS

Arthritis
Asthma
Atrial fibrillation / Atrial flutter
(circle which one if so)
Bleeding disorder
Chest pain
Congestive heart failure
Chronic lung disease (COPD)
Diabetes mellitus (DM)
Emphysema
Gastroesophageal reflux disease (GERD)
Heart disease
Past heart attack
High blood pressure (Hypertension)
High cholesterol (hypercholesterolemia)
History of cancer ______________________
HIV positive
Hepatitis
Mental Illness (Anxiety/Depression/Bipolar Disorder) *(circle one if so)*
Seizures
Stroke
Transient ischemic attack (TIA)
Tuberculosis (TB)
Recent hospitalization(s)?
Other *(list below)*

____
____
____
____